These charges are only allegations which may be contested by the licensee in an Administrative hearing.

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF DANIEL CAMERON, MD

STATEMENT

OF

CHARGES

Daniel Cameron, M.D., the Respondent, was authorized to practice medicine in New York State on or about January 14, 1985, by the issuance of license number 161183 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, a 41-year-old woman, from on or about January 28, 1997, through in or about June 2008. At the initial visit, the Patient reported leg pain, poor sleep and, that she had been evaluated by numerous physicians, for various joint complaints, with no definitive diagnosis. In March 1999, the Patient was admitted to a psychiatric facility for narcotic detoxification and upon discharge, returned to Respondent for continued treatment. In August 1999, based on ongoing complaints of poor concentration and fatigue, the Patient was evaluated at Helen Hayes Hospital and was diagnosed with Bipolar Disorder/Personality Disorder and Narcotic Abuse. In or about July 2003, the Patient moved to Florida. Respondent continued to provide the Patient with prescriptions for narcotics through 2005. (Patient names are identified in

the Appendix). Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

5. Respondent failed to follow-up, in a timely fashion, when the Patient developed possible adverse reactions to administered therapy.

6. Respondent inappropriately prescribed narcotics for the Patient.

7. Respondent inappropriately prescribed medication to the Patient without appropriate medical indications.

8. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to the Patient.

B. Respondent treated Patient B, a 38-year-old woman, from on or about October 15, 1998, through on or about March 7, 2008, for complaints that included severe fatigue,

disturbed sleep, irritability, joint pains, frequent sore throats, nausea and diarrhea. At her initial visit, the Patient reported that 9 years earlier she had been told she had a borderline Lyme test and was treated with antibiotics and, that in the past 5 years she had frequent bouts of fatigue and was diagnosed with Chronic Fatigue Syndrome. In December 1998, the Patient was seen by a neurologist who, based on an abnormal MRI, recommended a lumbar puncture but one was not done. In June 1999, the patient had an abnormal brain SPECT. In January 2002, the patient had her first and only physical examination in Respondent's practice. In January 2008, ten years after the initial MRI, the Patient had a second MRI, which was again abnormal and, a neurologist performed a lumbar puncture. The results of the lumbar puncture were negative for Lyme disease but revealed positive oligoclonal band proteins which are consistent with the diagnosis of Multiple Sclerosis. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent failed to obtain and/or review prior medical records to confirm the earlier diagnoses and treatment.

3. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

4. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

5. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent inappropriately prescribed medication to the patient without appropriate medical indications.

7. Respondent failed to order and/or perform a lumbar puncture to evaluate the Patient, based on ongoing complaints, an abnormal MRI and, an abnormal SPECT scan.

8. Respondent failed to reconsider a broad differential diagnosis based upon radiographic studies and ongoing complaints that included among other symptoms: slurred speech, memory loss, fatigue, headaches and worsening symptoms in the warm weather, thereby depriving the patient of an accurate diagnosis and years of effective therapy for her progressive disease.

9. Respondent failed to follow-up, in a timely fashion, when the Patient experienced possible adverse reactions to administered therapy.

10. Respondent failed to maintain records that accurately reflect the care and treatment rendered to the Patient.

C. Respondent treated Patient C, a 47-year-old male, from in or about January 1995, through in or about May 2009. The Patient suffered from morbid obesity and diabetes. In June 1999, the Patient presented with a diagnosis of phlebitis of his right leg.

Respondent began treating the Patient with parenteral antibiotics and thereafter, Respondent added the diagnosis of Lyme disease. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent treated the Patient inappropriately with an ongoing antibiotic regimen without further medical or surgical investigation of chronic venous insufficiency.

5. Respondent failed to maintain records that accurately reflects the care and treatment rendered to the Patient.

D. Respondent treated Patient D, a 49-year-old woman, from on or about October 10, 1997, through in or about February 2005. Respondent saw the Patient for evaluation of possible Lyme disease. At her initial visit, the Patient complained of problems with concentration, fatigue and, multiple joint pains. The Patient reported that she had previously been seen by a neurologist and had a normal MRI and CT scan. In December 1998, a neurologist recommended that Respondent order and/or perform

spinal fluid analysis but, this was not done. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent failed to appropriately evaluate the Patient, based on complaints of ongoing dizziness.

5. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent failed to maintain records that accurately reflects the care and treatment rendered to the Patient.

E. Respondent treated Patient E, a 46-year-old woman, from on or about July 8, 2008, through in or about August, 2008. At her initial visit, the Patient reported that she had been diagnosed with Parkinson's disease in May 2008, and that in early May 2008, she had a tick bite, a bull's eye rash and had been treated with antibiotics and intra muscular injections for approximately seven weeks. Respondent ordered a PICC

line for the administration of parenteral antibiotics, which was placed on July 17, 2008. One week later, the Patient complained of pain in her neck and shoulder. On July 31, 2008, the Patient reported extreme pain. The Patient had a venous Doppler study which indicated deep vein thrombosis. The Patient was admitted to Northern Westchester Hospital where the PICC line was removed and the patient was placed on anticoagulant therapy. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an appropriate history.

2. Respondent failed to obtain and/or review prior medical records to confirm the earlier diagnosis and treatment.

3. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

4. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

5. Respondent inappropriately treated the Patient with an antibiotic regimen without appropriate physical examinations and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent ordered and/or prescribed a PICC line and parenteral antibiotics without medical necessity.

7. Respondent failed to appropriately evaluate the Patient, in a timely fashion, when she complained of pain associated with the PICC line.

8. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to the Patient.

F. Respondent treated Patient F, a 36-year-old woman, on February 19, 2008, and May 5, 2008. The Patient reported that her recent medical history included a termination of pregnancy in October 2007, diverticulitis in November 2007 and, a diagnosis of Lyme disease for which she was treated with a five-week course of antibiotics in January 2008. Respondent's care and treatment deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an appropriate history.

2. Respondent failed to obtain and/or review prior medical records to confirm the earlier diagnosis and treatment.

3. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

4. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation including but not limited to other infections or inflammatory processes.

5. Respondent failed to appropriately follow-up on abnormal laboratory results including abnormal liver function tests and an elevated sedimentation rate.

6. Respondent failed to evaluate the Patient by ordering a CT scan of the abdomen and pelvis as well as additional blood testing.

7. Respondent failed to maintain a record that accurately reflects the care and treatment rendered to the Patient.

G. Respondent treated Patient G, a 28-year-old man, from on or about August 11, 2009, through on or about September 28, 2010. The Patient presented for evaluation of possible Lyme disease with complaints of headache, fatigue, memory loss, myalgia and back and neck pain. The Patient had a history of bipolar disorder for which he was under the care of a psychiatrist and, he had been diagnosed with and treated for Lyme disease 16 years earlier. A previous evaluation by a neurologist included negative MRI and MRA of the brain. Respondent's care and treatment of the Patient deviated from minimally accepted standards of care in that:

1. Respondent repeatedly failed to take and/or note an adequate history of present illness.

2. Respondent repeatedly failed to perform and/or note an appropriate physical examination.

3. Respondent failed to appropriately construct a differential diagnosis and pursue a thorough diagnostic evaluation.

4. Respondent failed to appropriately evaluate the Patient based on his ongoing complaints of chronic headaches and cognitive dysfunction.

5. Respondent treated the Patient inappropriately with an ongoing and escalating antibiotic regimen without appropriate sequential physical examinations

and clinical re-assessments for consideration of any alternative diagnoses and/or treatment.

6. Respondent inappropriately prescribed medications without appropriate medical indications and/or without considering possible drug interactions.

7. Respondent failed to follow-up, in a timely fashion, when the Patient experienced possible side effects.

8. Respondent failed to follow-up appropriately on abnormal test results.

9. Respondent failed to maintain records that accurately reflects the care and treatment rendered to the Patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its

subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

2. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

THIRD THROUGH NINTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. Paragraph A and its subparagraphs.

4. Paragraph B and its subparagraphs.

5. Paragraph C and its subparagraphs.

6. Paragraph D and its subparagraphs.

7. Paragraph E and its subparagraphs.

8. Paragraph F and its subparagraphs.

9. Paragraph G and its subparagraphs.

TENTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

10. Paragraph A and its subparagraphs and/or Paragraph B and its subparagraphs and/or Paragraph C and its subparagraphs and/or Paragraph D and its subparagraphs and/or Paragraph E and its subparagraphs and/or Paragraph F and its subparagraphs and/or Paragraph G and its subparagraphs.

ELEVENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

11. Paragraph A and A (8) and/or Paragraph B and B(10) and/or Paragraph C and C(5) and/or Paragraph D and D(6) and/or Paragraph E and E(8) and/or Paragraph F and F(7) and/or Paragraph G and G(9).

DATE: April 27, 2017
New York, New York

[redacted]

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct